

## NY STATE CLIENT SEMI-ANNUAL REPORT

CSR 52436

Marking Instructions: Please type or use blue or black ink pen.  
Completely fill in one circle.  
Print legible numbers and block letters, no script.

COMPLETE ALL SECTIONS  
before submitting or form will be returned.

## I Reporting Information

Year: 2013

Fill in circle if amendment ☐Report Period: ☒ January/June ☐ July/DecemberType of Lobbying: ☒ Nonprocurement ☐ Procurement ☐ Both

Client Filing Fee Check Number:

FOR OFFICE USE ONLY

cjm IV. (C) 1st exp. date 2/28/13  
system would not accept 2/29/13.  
REC'D JUL 15 2013 XI: CAO  
ENT'D AUG 08 2013 132031  
CL# 2544 \$ 50.-

## II Client Information

Name: ASSOCIATION OF HEALTH CARE PROVIDERS, INC. (NYS)

Permanent Business Address: 20 CORPORATE WOODS, 2ND FLOOR

City: ALBANY

State: NY

ZIP code: 12211

Business Phone: 518-463-1118

Fax Number: 518-463-1606

Third Party Beneficiary (see instructions):

## III Lobbyist(s) Information &amp; Compensation (Current Period Only)

Any individual or organization that has lobbied on behalf of the client must be reported below, regardless of whether the threshold was exceeded by that individual or organization.

A Type of Lobbyist: ☐ Retained ☒ Employed ☐ DesignatedLevel of Gov't: ☐ State Lobbying ☐ Local Lobbying ☒ Both

Name: JOHNSTON, CHRISTINE (FKA WANG, PHYLLIS A.)

Phone Number: 518-463-1118

Address: 20 CORPORATE WOODS, 2ND FLOOR

City: ALBANY

State: NY

ZIP code: 12211

Compensation for current period: \$100300 .00

B Type of Lobbyist: ☐ Retained ☒ Employed ☐ DesignatedLevel of Gov't: ☐ State Lobbying ☐ Local Lobbying ☒ Both

Name: MEGAN TANGJERD

Phone Number: 518-463-1118

Address: 20 CORPORATE WOODS, 2ND FLOOR

City: ALBANY

State: NY

ZIP code: 12211

Compensation for current period: \$25760 .00

C Type of Lobbyist: ☐ Retained ☒ Employed ☐ DesignatedLevel of Gov't: ☐ State Lobbying ☐ Local Lobbying ☒ Both

Name: CATHERINE TULLY

Phone Number: 518-463-1118

Address: 20 CORPORATE WOODS, 2ND FLOOR

City: ALBANY

State: NY

ZIP code: 12211

Compensation for current period: \$29930 .00

☒ Continued on attached pages

D TOTAL COMPENSATION of ALL lobbyists for current period.....(A+B+C+addendum sheets): \$182240 .00

**Designated Addendum sheet for sections III and IV**

Please use the following addendum pages as continuation for the specified sections. If additional space is needed, please make a copy of this sheet.

**III Lobbyist(s) Information & Compensation (Current Period Only)**

Any individual or organization that has lobbied on behalf of the client must be reported below, regardless of whether the threshold was exceeded by that individual or organization.

Type of Lobbyist: ☒ Retained ☐ Employed ☐ Designated

Level of Gov't: ☒ State Lobbying ☐ Local Lobbying ☐ Both

Name: WEINGARTEN, REID, & MCNALLY, LLC (FKA WEINGARTEN&REID, LLC) Phone Number: 518-465-7330

Address: 1 COMMERCE PLAZA

City: ALBANY

State: NY

ZIP code: 12210

Compensation for current period: \$26250 .00

Type of Lobbyist: ☐ Retained ☐ Employed ☐ Designated

Level of Gov't: ☐ State Lobbying ☐ Local Lobbying ☐ Both

Name:

Phone Number:

Address:

City:

State:

ZIP code:

Compensation for current period: \$ .00

Type of Lobbyist: ☐ Retained ☐ Employed ☐ Designated

Level of Gov't: ☐ State Lobbying ☐ Local Lobbying ☐ Both

Name:

Phone Number:

Address:

City:

State:

ZIP code:

Compensation for current period: \$ .00

**IV Other Expenses (Current Semi-Annual Period Only)**

PAID TO: WEINGARTEN, REID, & MCNALLY, LLC

DATE: 06 /30 / 2013

☐ Ad

☐ Social Event

PURPOSE: REIMBURSED EXPENSES

AMOUNT: \$199 .00

☐ \*Addendum attached

☐ PROCUREMENT ☒ NONPROCUREMENT

PAID TO:

DATE: / /

☐ Ad

☐ Social Event

PURPOSE:

AMOUNT: \$ .00

☐ \*Addendum attached

☐ PROCUREMENT ☐ NONPROCUREMENT

PAID TO:

DATE: / /

☐ Ad

☐ Social Event

PURPOSE:

AMOUNT: \$ .00

☐ \*Addendum attached

☐ PROCUREMENT ☐ NONPROCUREMENT

PAID TO:

DATE: / /

☐ Ad

☐ Social Event

PURPOSE:

AMOUNT: \$ .00

☐ \*Addendum attached

☐ PROCUREMENT ☐ NONPROCUREMENT

PAID TO:

DATE: / /

☐ Ad

☐ Social Event

PURPOSE:

AMOUNT: \$ .00

☐ \*Addendum attached

☐ PROCUREMENT ☐ NONPROCUREMENT



**IV Other Expenses (Current Semi-Annual Period Only)**

**A** Report in the aggregate all expenses less than or equal to \$75: \$ 0 .00

**B** Report in the aggregate all expenses for salaries of non-lobbying employees: \$ 0 .00

**C Itemize each expense exceeding \$75:**

PAID TO: WEINGARTEN REID & MCNALLY, LLC DATE: 02 / 29 / 2013 ☐ Ad ☐ Social Event  
PURPOSE: REIMBURSED EXPENSES AMOUNT: \$ 261 .00 ☐ \*Addendum attached  
☐ PROCUREMENT ☒ NONPROCUREMENT

PAID TO: WEINGARTEN REID & MCNALLY, LLC DATE: 04 / 30 / 2013 ☐ Ad ☐ Social Event  
PURPOSE: REIMBURSED EXPENSES AMOUNT: \$ 194 .00 ☐ \*Addendum attached  
☐ PROCUREMENT ☒ NONPROCUREMENT

☒ Continued on attached pages

\* If any expense listed above exceeds \$75 for an individual, you must attach the addendum page listing the expense, dollar amount attributable to the individual and the name, title and employer of the individual.

**D** Total expenses for current period: \$654 .00 (if applicable, include all expenses from attached pages in total)

**V Source of Funding Disclosure**

**Instructions:** In the event only one person or entity is listed as the Single Source for a Contribution(s), use Section A. In the event multiple persons or entities have been aggregated as a Single Source for a Contribution(s), use Section B.  
**A** Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received. If more than five Contributions from the Single Source have been received, use section V(C) of the Addendum for the additional Contributions.

**Contribution(s) from Single Source #1**

Single Source Entity's Name: NEW YORK HEALTH CARE

or  
Single Source Person's Last Name: First Name:

Address: 20 EAST SUNRISE HWY

City: VALLEY STREAM

State: NY

ZIP code: 11581

Phone: 718-375-6700

Date Contribution Received: 01 / 01 / 2013 Amount of Contribution: \$ 649 .00

Date Contribution Received: 01 / 15 / 2013 Amount of Contribution: \$ 649 .00

Date Contribution Received: 01 / 23 / 2013 Amount of Contribution: \$ 622 .00

Date Contribution Received: 04 / 24 / 2013 Amount of Contribution: \$ 649 .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

**Contribution(s) Single Source #2**

Single Source Entity's Name: PEOPLE CARE INCORPORATED

or  
Single Source Person's Last Name: First Name:

Address: 4 NORTH JERUSALEM AVE.

City: HICKSVILLE

State: NY

ZIP code: 11801

Phone: 516-433-2600

Date Contribution Received: 01 / 25 / 2013 Amount of Contribution: \$ 938 .00

Date Contribution Received: 04 / 19 / 2013 Amount of Contribution: \$ 67 .00

Date Contribution Received: 04 / 24 / 2013 Amount of Contribution: \$ 938 .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

Check here if there are Contribution(s) from Single Source(s) other than those listed above. Use Section V(A) of the Addendum to list all such Contributions: ☒

**Designated Addendum sheet for section V(A)**

Please use the following addendum pages as continuation for the specified sections. If additional space is needed, please make a copy of this sheet.

**V Source of Funding Disclosure**

**A** Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received.

**Contributions from Single Source #3**

Single Source Entity's Name: PREMIER HOME HEALTH CARE SERVICES

or

Single Source Person's Last Name:

First Name:

Address: 445 HAMILTON AVE., 10TH FLOOR

City: WHITE PLAINS

State: NY

ZIP code: 10601

Phone: 914-428-7722

Date Contribution Received:	02	/	13	/	2013	Amount of Contribution:	\$1012	.00
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Date Contribution Received:	06	/	17	/	2013	Amount of Contribution:	\$1012	.00
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Date Contribution Received:	/	/				Amount of Contribution:	\$	.00
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Date Contribution Received:	/	/				Amount of Contribution:	\$	.00
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Date Contribution Received:	/	/				Amount of Contribution:	\$	.00
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Check here if using section V(C) of the Addendum for additional Contributions: ☐

**Contributions from Single Source # 4**

Single Source Entity's Name: PERSONAL TOUCH HOME CARE, INC.

or

Single Source Person's Last Name:

First Name:

Address: 222-15 NORTHERN BLVD.

City: BAYSIDE

State: NY

ZIP code: 11361

Phone: 718-468-4747

Date Contribution Received:	01	/	25	/	2013	Amount of Contribution:	\$ 1012	.00
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Date Contribution Received:	04	/	24	/	2013	Amount of Contribution:	\$ 1012	.00
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Date Contribution Received:	/	/				Amount of Contribution:	\$	.00
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Date Contribution Received:	/	/				Amount of Contribution:	\$	.00
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Date Contribution Received:	/	/				Amount of Contribution:	\$	.00
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Check here if using section V(C) of the Addendum for additional Contributions: ☐

**Contributions from Single Source # 5**

Single Source Entity's Name: ALLEN HEALTH CARE SERVICES

or

Single Source Person's Last Name:

First Name:

Address: 70-00 AUSTIN ST., SUITE 201

City: FOREST HILLS

State: NY

ZIP code: 11375

Phone: 718-689-1201

Date Contribution Received:	01	/	31	/	2013	Amount of Contribution:	\$863	.00
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Date Contribution Received:	04	/	24	/	2013	Amount of Contribution:	\$863	.00
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Date Contribution Received:	/	/				Amount of Contribution:	\$	.00
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Date Contribution Received:	/	/				Amount of Contribution:	\$	.00
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Date Contribution Received:	/	/				Amount of Contribution:	\$	.00
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Check here if using section V(C) of the Addendum for additional Contributions: ☐



**Designated Addendum sheet for section V(A)**

Please use the following addendum pages as continuation for the specified sections. If additional space is needed, please make a copy of this sheet.

**V Source of Funding Disclosure**

**A** Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received.

**Contributions from Single Source # 6**

Single Source Entity's Name: *Maxim Health Care Services*

or  
Single Source Person's Last Name:

First Name:

Address: *7227 Lee Deforest Dr.*

City: *Columbia*

State: *MD*

ZIP code: *21046*

Phone: *410-910-1500*

Date Contribution Received: *02 / 04 / 2013* Amount of Contribution: \$ *2685* .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

**Contributions from Single Source # 7**

Single Source Entity's Name: *All Metro Health Care*

or  
Single Source Person's Last Name:

First Name:

Address: *50 Broadway*

City: *Lynbrook*

State: *NY*

ZIP code: *11563*

Phone: *516-887-1200*

Date Contribution Received: *02 / 20 / 2013* Amount of Contribution: \$ *938* .00

Date Contribution Received: *05 / 13 / 2013* Amount of Contribution: \$ *938* .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

**Contributions from Single Source # 8**

Single Source Entity's Name: *Bestcare, Inc.*

or  
Single Source Person's Last Name:

First Name:

Address: *3000 Hempstead Turnpike, Ste. 205*

City: *Lewittown*

State: *NY*

ZIP code: *11756*

Phone: *516-731-3790*

Date Contribution Received: *05 / 15 / 2013* Amount of Contribution: \$ *938* .00

Date Contribution Received: *05 / 03 / 2013* Amount of Contribution: \$ *938* .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

**Designated Addendum sheet for section V(A)**

Please use the following addendum pages as continuation for the specified sections. If additional space is needed, please make a copy of this sheet.

**V Source of Funding Disclosure**

**A** Below, list all Contributions received from the Single Source. Include the date and the amount of the Contribution received.

**Contributions from Single Source # 9**

Single Source Entity's Name: Access Nursing Services

or  
Single Source Person's Last Name:

First Name:

Address: 16 East 40th St., 3rd Floor

City: New York

State: NY

ZIP code: 10016

Phone: 646-346-1620

Date Contribution Received: 01 / 04 / 2013 Amount of Contribution: \$ 1725 .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

**Contributions from Single Source # 10**

Single Source Entity's Name: Unlimited Care, Inc.

or  
Single Source Person's Last Name:

First Name:

Address: 333 Westchester Ave, West Bldg, Ste. W602

City: White Plains

State: NY

ZIP code: 10604

Phone: 914-428-4300

Date Contribution Received: 01 / 25 / 2013 Amount of Contribution: \$ 863 .00

Date Contribution Received: 04 / 24 / 2013 Amount of Contribution: \$ 863 .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Check here if using section V(C) of the Addendum for additional Contributions: ☐

**Contributions from Single Source # 11**

Single Source Entity's Name: WILLCARE

or  
Single Source Person's Last Name:

First Name:

Address: 346 Delaware Ave.

City: Buffalo

State: NY

ZIP code: 14202

Phone: 716-856-7500

Date Contribution Received: 01 / 25 / 2013 Amount of Contribution: \$ 863 .00

Date Contribution Received: 04 / 24 / 2013 Amount of Contribution: \$ 863 .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Date Contribution Received: / / Amount of Contribution: \$ .00

Check here if using section V(C) of the Addendum for additional Contributions: ☐



**VI** Subjects lobbied:

HEALTH CARE FINANCING & BUDGET; HOME HEALTH & STAFFING; INSURANCE & WORKERS' COMP

☐ Continued on attached pages

**VII** Person, State Agency, Municipality or Legislative Body lobbied:

DEPTS HEALTH, SOCSVS, AGING, INSURANCE; LEGISLATURE/LEGISLATIVE COMMITTEES; WORKERS' COMP BOARD

☐ Continued on attached pages

**VII** Bill, Rule, Regulation, Rate Number or brief description relative to the introduction or intended introduction of legislation or a resolution on which you lobbied:

A4473, S2603, S2606, A3003, A3006, A2482, S2313, S3902, A5705, S3966A, A6530, S4719, A7845, S5331, A7530, A2675, S5217, A7309, A3000, A3005, S2600, S2605,

☐ Continued on attached pages

**VIII** Title and Identifying Numbers of procurement contracts/documents lobbied:

NONE

☐ Continued on attached pages

**IX** Number or Subject Matter of Executive Order of Governor/Municipality lobbied:

NONE

☐ Continued on attached pages

**X** Subject Matter of and Tribes involved in tribal-state compacts, etc lobbied:

NONE

☐ Continued on attached pages

**XI Declaration**

This Declaration must be signed by the Chief Administrative Officer. (If the Chief Administrative Officer, for any reason, does not sign, he/she must duly designate another person to sign this Declaration.) (See instructions.)

**I declare under penalty of perjury that the information contained in this report is true, correct, and complete to the best of my knowledge and belief.**

**X** SIGNATURE: 

DATE: 07/12/2013

PRINT NAME: LAST JILL

FIRST COUNIHAN

TITLE: OPERATIONS OFFICER

Mark One: ☐ Chief Administrative Officer ☒ Designee(Attach Letter)

**The following MUST be attached to this report at the time of submission:**

- You must attach a **\$50 dollar filing fee** to each semi-annual report. (No fee is required for amendments to the original)
- If applicable, a designation letter if you have marked designee in section XI.
- If applicable, continuation sheets for sections III, IV, V, VI, VII, VIII, IX and X.

**PLEASE NOTE** You may be assessed up to \$25 for each day this report is late.